



MaineCare Value-Based Purchasing Strategy Design Management Committee

February 6, 2012

<http://www.maine.gov/dhhs/oms/vbp>

Agenda

- **Health Homes Update & Next Steps**
- **RFI Accountable Communities Feedback Sought & Responses**
- **RFI Interest in Accountable Communities**
- **Accountable Communities Decision Points & RFI Feedback**
 - **Accountable Community (AC) composition & governance**
 - **Requirements for behavioral and physical care integration**
 - **Requirements for collaboration with the community**
- **Agenda for remaining DMC meetings**

In November 2011, the Department released a “Request for Information” (RFI) seeking information on the following. Submissions were due December 21, 2011.



Accountable Communities

- Interest of organizations
- AC membership, governance, collaboration
- Consumer & family involvement
- Consumer advocacy and involvement
- Payment models
- Assumption of risk
- “Impactable” costs of care
- Performance measures
- Data sharing and analytics
- Member attribution

The RFI is posted on the Department’s Value-Based Purchasing website at:
<http://www.maine.gov/dhhs/oms/vbp>

•Who Responded to the RFI

Twenty eight Responders:

- **Health Systems (5)**
 - Eastern Maine Healthcare Systems
 - MaineGeneral Health
 - MaineHealth
 - Mercy Health System
 - St. Mary's Regional Medical Center
- **Behavioral Health Organizations (12)**
 - Amistad (also listed as Advocacy Organization)
 - Aroostook Mental Health Center
 - Assistance Plus
 - Beacon Health Strategies
 - Behavioral Health Community Collaborative (5 agencies)
 - Charlotte White Center
 - Community Health and Counseling Services
 - Crisis and Counseling Centers
 - Merrimack River Medical Services,
 - Motivational Services
 - OHI (also listed as Long Term Care Organization)
 - Providence Service Corp

Who Responded to the RFI

- **Health Plans/Administrative Services Organizations (ASOs) (4)**
 - Anthem
 - APS
 - Magellan Health Services
 - Outcomes Pharmaceutical (Also listed as Pharmacy)
- **Long Term and Home Care Services (3)**
 - Androscoggin Home Health and Hospice
 - OHI
 - Seniors Plus
- **Advocacy Groups (3)**
 - Amistad
 - Maine Equal Justice Partners/Consumers for Affordable Health Care
 - NAMI
- **Pharmacy (2)**
 - National Association Chain Drug Stores
 - Outcomes Pharmaceutical (also
- **Primary Care(2)**
 - Dr. Jean Antonucci
 - Maine Primary Care Association

RFI Response: Accountable Communities

Interest in Accountable Communities Participation

- High level of interest in Accountable Communities Project
- Response shows active interest by behavioral health and large health care systems. Limited response by unaffiliated PCPs, long term care, home health, and other social service providers
- All responders support emphasis on integrating physical and behavioral care and including community organizations in AC
- General agreement with gradual transition from FFS to shared savings/ shared risk model

Decision Points: Models of Care

1. What are requirements for AC composition and/or governance?
2. Will there be requirements ACs must meet to demonstrate that they are collaborating with area health and social service organizations?
3. Will there be requirements ACs must meet to demonstrate the integration of behavioral and physical health across their providers?

Accountable Communities: MaineCare's Stated Basic Model Components



- Open to any willing and qualified providers statewide
 - Qualified providers will be determined through an RFP or application process
 - Accountable Communities will not be limited by geographical area
- Members retain choice of providers
- Alignment with aspects of other emerging ACOs in the state wherever feasible and appropriate
- Flexibility of design to encourage innovation

To serve the unique needs of the MaineCare population:

- Requirement that Accountable Communities collaborate with other providers, hospitals, and social service organizations in the community
- Focus on integration of physical and behavioral health
- Strong interest in proposals to serve highest need populations

RFI Statement re AC Collaboration

“...The Department plans to require Accountable Communities to collaborate with health care, community, and social service providers within the area where their members predominantly receive services, including, but not limited to,

- hospitals,
- clinics,
- private practice offices,
- physicians,
- behavioral health care providers,
- dentists, and
- other social service agencies or organizations.

Collaboration may take the form of inclusion on a governing board, Memoranda of Understanding, contractual agreements, or other proposed relationships or activities. Accountable Communities must demonstrate plans to collaborate with primary care providers, *all* hospitals within the predominant catchment area, and at least one consumer organization capable of advocating on behalf of members residing within the Accountable Communities catchment area.

RFI Response: Accountable Communities



- **Who will be included as AC provider participants?**
 - » Most responses indicate that ACs should include primary care and behavioral health providers and collaborate with social service, care coordinators and other community groups.
 - » Many behavioral health agencies would like more requirements to demonstrate full integration between physical and behavioral health care.
- **Can any health organization or provider be the lead member of an AC?**
 - » Responses stated that many ACs may be led by hospitals. Any barriers for other providers/ groups to join together to create an AC for defined populations?
- **Governance & Collaboration is described in many ways by the responders.**
 - » Health systems plan for Memoranda of Understanding (MOU) relationships with outside partners.
 - » Behavioral health organizations seek more formal arrangements for AC collaboration and shared decision-making.

RFI Response: Accountable Communities



– Collaboration Plans

- » Health Systems indicated an intent to partner with retirement, behavioral health organizations, long term care, Community Care Teams and peer support organizations
- » Most behavioral health organizations support a model including all physical and behavioral health providers; several recommend the following requirements for ACs
 - Require independent advocacy org be part of AC
 - Require evidence of strong connection between Health Homes and ACs

– Geographic & Participation Limitations

- » Some health systems and the health plans believe too many ACs within one area and providers in multiple ACs limit ability to manage care and achieve performance measures.
- » Most behavioral health organizations favor an “any willing provider” approach to AC membership and note that most providers work across multiple systems.

Requirements from other Medicare & Medicaid ACO Models

Model	Eligible Providers	Governance
Medicare Pioneer ACO/ Shared Savings	(1) group practice arrangements; (2) networks of individual practices; (3) partnerships between hospitals and physicians; (4) hospitals employing physicians; or (5) FQHCs.	Recognized separate legal entity, governing body controlled by at least 75% of ACO participants, include one or more Medicare beneficiaries who are served by the ACO.
Minnesota: Health Care Delivery Systems (HCDS)	Deliver the full scope of primary care services and directly deliver or demonstrate the ability to coordinate with specialty providers and hospitals. Include formal and informal partnerships with community organizations, social service agencies, etc. in the care delivery model. Engage patients and families in organizational quality improvement activities and leadership roles	HCDS indicates accountable fiscal entity
New Jersey	Local hospitals and 75% of qualified PCPs in the designated service area must support the application.	501c(3). Governing board that includes health care stakeholders and voting representation from at least two consumer organizations. ACOs must have a process to distribute revenue from gain-sharing to participating providers and a process for engaging the community.
Colorado	1) Certified Medicaid provider, or 2) FQHC, clinic or group practice, or individual physician with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology	

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Discussion Questions

- If we leave it up to ACs to dictate how they will collaborate, involve members and family in leadership, integrate behavioral and physical health, etc, how do we know/ ensure this happens? Or is simply tracking quality outcomes and costs what matters?
- How to ensure that hospitals coordinate with providers outside their Accountable Community/ Health System?
- Other?

Agendas for Upcoming DMC Meetings

- **2/13:** Continuation of Health Homes discussion:
 - Additional requirements to ensure Health Homes meet the needs of children and individuals with behavioral health issues
 - Quality reporting
- **2/27:**
 - Core services for which all Accountable Communities will be responsible
 - Performance/ quality measures
- **3/5** (location TBD):
 - Member attribution
 - Risk-sharing: tiers, calculation